STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011517	A. BUILDING: _____ B. WING _____	C 05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAXIMUM HOME HEALTH CARE INC	8220 CALUMET AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a home health state complaint investigation. Complaint # IN00128337 - Substantiated: No deficiencies related to the allegation are cited. Unrelated deficiencies are cited. Dates: 05/20-22/13 Medicaid #: 200932770 Surveyor: Janet Brandt, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN May 28, 2013	N 000		
N 522	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure visits and treatments were completed only as ordered on the plan of care for 3 (#1, #2, #4) of 4 records reviewed with the potential to affect all of the agency's patients. The findings include: 1. Clinical record #1, Start of Care (SOC) 2 -25-13, included a plan of care for the certification period 4-26-13 to 6-14-13 with orders for skilled nurse one time per week for 9 weeks. The record failed to evidence a skilled nurse visit was made	N 522		

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N 522	Continued From page 1 week 1, 4-26-13 to 4-27-13. 2. Clinical record #2, SOC 1-7-13, included a plan of care for the certification period 3-8-13 to 5-6-13 with orders for skilled nursing visits 2 times weekly for 9 weeks. The record failed to evidence any skilled nurse visits were made week 1, 3-8-13 to 3-9-13. The record evidenced only one skilled nurse visit was made week 3. 3-17-13 to 3-23-13; week 7, 4-14-13 to 4-20-13; and week 8, 4-28-13 to 5-4-13 3. Clinical record #4, SOC 6-29-12, included a plan of care for the certification period 2-24-13 to 4-24-13 with physician orders for skilled nurse to visit 1 time weekly starting week 2 and a home health aide to visit 2 times weekly starting week 2 (3-3-13 to 3-9-13) for 8 weeks. The patient was discharged 4/24/13. A. The record failed to evidence a skilled nursing visit was made week 3, 3-10-13 to 3-16-13; week 4, 3-18-13 to 3-23-13; week 6, 3-31-13 to 4-6-13; or week 9, 4-21-13 to 4-24-13. B. A home health aide visit was missed during week 9, 4-21-13 to 4-24-13. C. A skilled nursing visit was documented on 4-25-13, after the certification period ended and after the patient was discharged, by Employee B, who performed a blood draw and treated a resulting skin tear with topical medication and a gauze dressing. The plan of care failed to evidence an order for these treatments. D. A home health aide visit was documented for 4-25-13 and 5-1-13, after the certification period ended and after the patient was discharged.	N 522		

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N 522	Continued From page 2 4. On interview on 5-21-13 at 1:30 PM CST, Employee B stated, "I goofed and went to visit the patient after the certification period ended. On 4-25-13 I made a skilled nursing visit and I did a blood draw. The home health aide was also there. The patient experienced a skin tear probably because the skin was very fragile and the patient was on Coumadin [blood thinner]. I had the home health aide hold the patient's arm because of the tremor the patient had. That may have caused the skin tear; I don't know. I put wound cream on it and dropped a 4x4 gauze dressing on it and wrapped it in Kerlix. The day after the blood draw the family member called and indicated they wanted a different nurse to do visits [due to skin tear] but they wanted to keep the home health aide. We could not find another nurse to fit their scheduling needs so we discharged the patient effective 4-24-13, which was the end of the certification period, and I obtained the physician order to discharge effective 4-24-13 per family request."	N 522		
N 527	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This RULE is not met as evidenced by: Based on interview, medical record review, and policy review, the agency failed to ensure the registered nurse notified the physician of a patient's wound for 1 (#4) of 4 records reviewed	N 527		

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N 527	Continued From page 3 with the potential to affect all patients of the agency. Findings include: 1. Record #4, start of care 6-29-12, evidenced the patient was discharged 4-24-13. A skilled nursing visit was documented on 4-25-13, after the certification period ended and after the patient was discharged, by Employee B, who performed a blood draw and treated a resulting skin tear with topical medication and a gauze dressing. The plan of care failed to evidence an order for these treatments. The record failed to evidence the physician was notified of the skin tear. 2. On 5-21-13 at 1:30 PM CST, Employee B indicated there was no documentation that the physician was notified of the skin tear and the nurse's treatment of the wound or documentation of the size of the wound. 3. The agency policy "Monitoring Patient's Response / Reporting to Physician" policy #2-029.1 revised October 2011 states, "Policy: ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient."	N 527		
N 537	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure drugs and treatments	N 537		

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N 537	Continued From page 4 were provided only as ordered on the plan of care for 1 (#4) of 4 records reviewed with the potential to affect all patients of the agency. Findings include: 1. Clinical record #4, start of care 6/29/12, identified the patient was discharged 4/24/13, the end of the certification period. A skilled nursing visit was documented on 4-25-13, after the certification period ended and after the patient was discharged, by Employee B, skilled nurse, who performed a blood draw and treated a resulting skin tear with topical medication and a gauze dressing. The plan of care failed to evidence an order for these treatments. 2. Employee B indicated on 5-21-13 at 1:30 PM a nursing visit and blood draw was done after the patient #4 was discharged from the agency, on 4-25-13. Immediately after the blood draw was done the patient was noted to have a skin tear on the left hand which Employee B "covered with wound cream and dropped a 4x4 gauze on it and wrapped it in kerlix."	N 537		
N 546	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.	N 546		

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N 546	Continued From page 5 This RULE is not met as evidenced by: Based on interview, medical record review, and policy review, the agency failed to ensure the registered nurse notified the physician of a patient's wound for 1 (#4) of 4 records reviewed with the potential to affect all patients of the agency. Findings include: 1. Record #4, start of care 6-29-12, evidenced the patient was discharged 4-24-13. A skilled nursing visit was documented on 4-25-13, after the certification period ended and after the patient was discharged, by Employee B, who performed a blood draw and treated a resulting skin tear with topical medication and a gauze dressing. The plan of care failed to evidence an order for these treatments. The record failed to evidence the physician was notified of the skin tear. 2. On 5-21-13 at 1:30 PM CST, Employee B indicated there was no documentation that the physician was notified of the skin tear and the nurse's treatment of the wound or documentation of the size of the wound. 3. The agency policy "Monitoring Patient's Response / Reporting to Physician" policy #2-029.1 revised October 2011 states, "Policy: ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient."	N 546		